



Accessible Version

April 13, 2016

Congressional Requesters

Medicare: Opportunities Exist to Recover Potential Overpayments to Providers with Criminal Backgrounds

In June 2015, we issued a report on Medicare's provider and supplier enrollment screening procedures to determine the extent to which the Provider Enrollment, Chain and Ownership System (PECOS) is vulnerable to fraud. PECOS is a centralized database designed to contain providers' and suppliers' enrollment information. In our report, we found that two Centers for Medicare & Medicaid Services (CMS) procedures appear to be working to screen for providers and suppliers listed as deceased or excluded from participating in federal programs or health care-related programs. However, we identified weaknesses in two of CMS's procedures related to verifying provider practice locations and physician licensure status.¹ We recommended that CMS incorporate flags into its software to help identify questionable addresses, revise its 2014 guidance for verifying practice locations, and collect additional license information.²

This correspondence provides the results of our assessment of CMS's procedures to verify criminal-background information for providers and suppliers in PECOS, as well as a description of the steps that CMS has taken, in the interim, to update its criminal-background check process. We were not able to incorporate this assessment into our June 2015 report because of the length of time that it took to obtain the data, assess their reliability, and analyze the results. Our findings are based on data from 2013, the most-current data available to us at the time of our review. CMS implemented new procedures in April 2014 to update its criminal-background check process. Although CMS has new procedures in place, the results of our review of the 2013 data provide an opportunity for CMS to recover potential overpayments that were made prior to putting the revised procedures in place.

To assess the extent to which CMS has controls in place to verify criminal-background information for providers and suppliers in PECOS, we matched the PECOS data of approximately 1.2 million unique physicians and nonphysicians, such as physician assistants, clinical social workers, and nurse practitioners, as of March 2013, to data from the Federal Bureau of Prisons and the National Sex Offender Registry as of February 2014, by Social Security number, name, and date of birth, to identify potentially ineligible providers. We reviewed CMS supporting documentation and interviewed agency officials to understand how CMS controls were applied to Medicare providers and suppliers that we identified as matches to

¹See GAO, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, GAO-15-448 (Washington, D.C.: June 25, 2015).

²The Department of Health and Human Services (HHS) concurred with two of the three recommendations, but did not agree with the recommendation to revise its guidance because it believed that incorporating software flags would be sufficient. However, we continue to believe the recommendation is valid. As of February 2016, HHS stated that it started to implement one of the three recommendations; however, it is too early for us to determine whether the agency actions outlined in its official comments would fully address the intent of the recommendations.

the law-enforcement databases. We contacted the Medicare Administrative Contractors (MAC) to obtain updates on the providers' status in PECOS as of September 2015. On the basis of MACs' responses, we determined whether the providers had been removed from the Medicare program subsequent to March 2013 or whether they remained in the system.

We also calculated Medicare claims that were paid to providers while they were potentially ineligible. We assessed the reliability of the PECOS, Federal Bureau of Prisons, National Sex Offender Registry, and Medicare claims data by reviewing relevant documentation, interviewing knowledgeable agency officials, and performing electronic testing to determine the validity of specific data elements in the databases, and determined that these databases were sufficiently reliable for the purpose of our review. We did not review about 316,000 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, Home Health Agencies (HHA), or other providers that did not have an individual Social Security number, name, and date of birth associated with their PECOS profiles in the data we received, because these data elements were necessary to facilitate our data matching.

In order to provide an overview of the steps that CMS has taken to update its criminal-background check process, we reviewed federal regulations and CMS procedural manuals that outline the procedures that MACs should use to determine provider and supplier enrollment eligibility. We met with CMS officials to better understand CMS controls in verifying criminal-background information on providers and suppliers prior to April 2014 and controls implemented after April 2014 under CMS's new validation procedure. We did not assess the new procedure for effectiveness because the data available to us were based on procedures in place in 2013. Although CMS has new procedures in place, the results of our review of the 2013 data are still outstanding and provide an opportunity for CMS to recover potential overpayments from that time.

We conducted this performance audit from June 2015 to April 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS requires Medicare providers and suppliers to have an enrollment record in the Internet-based PECOS before they bill for services provided to Medicare beneficiaries.³ PECOS is a centralized database that contains enrollment information for providers and suppliers. According to CMS, about 1.9 million providers and suppliers were listed in PECOS, as of December 2015. In addition, CMS is responsible for developing provider and supplier enrollment procedures to help safeguard the program from fraud, waste, and abuse. CMS has contracted with MAC and the National Supplier Clearinghouse (NSC) to manage the enrollment process. MACs are responsible for verifying provider and supplier application information in PECOS before the providers and suppliers are enrolled in Medicare. The NSC is responsible for verifying Medicare

³The term "provider" refers collectively to institutional providers such as hospitals and health-care facilities, as well as physicians and nonphysician practitioners who provide health-care services to Medicare beneficiaries. Providers also include organ-procurement organizations, skilled-nursing facilities, hospice, and end-stage renal disease centers. The term "supplier" refers to certain Part B entities such as ambulance-service providers, mammography centers, and portable X-ray facilities. Suppliers also include entities that supply Medicare beneficiaries with Medicare DMEPOS such as walkers and wheelchairs.

DMEPOS supplier's information. CMS requires providers and suppliers to revalidate the accuracy of their enrollment information with the relevant MAC every 5 years to maintain billing privileges. DMEPOS suppliers must revalidate information with the NSC every 3 years.⁴ CMS may deny or revoke a provider's or supplier's enrollment in the Medicare program if, within the 10 years before enrollment or revalidation of enrollment, the provider, supplier, or any owner or managing employee of the provider or supplier was convicted of a federal or state felony offense, including certain felony crimes against persons, that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.⁵

Opportunities Exist to Recover Potential Overpayments from a Few Providers Who Entered Medicare before CMS Implemented New Background Checks

Opportunities exist for CMS to recover about \$1.3 million in potential overpayments to 16 out of 66 potentially ineligible providers with criminal backgrounds who were enrolled in Medicare before CMS implemented more extensive background check processes in April 2014. These 16 providers had Medicare claims paid to them while they were potentially ineligible. However, we plan to refer all 66 providers to CMS for further investigation. CMS can recover outstanding potential overpayments made to potentially ineligible Medicare providers within: 1 year of the initial determination or redetermination for any reason; within 4 years of the initial determination or redetermination for good cause such as new and material evidence; or at any time if reliable evidence exists that the initial determination was procured by fraud. In addition, CMS can revoke certain providers and suppliers from the Medicare program if it discovers that providers or suppliers failed to self-report any final adverse legal action within 30 days, or if it discovers that providers, suppliers, or any owner or managing employee of the provider or supplier was convicted of a federal or state felony, such as felony crimes against persons, within the last 10 years preceding revalidation. Providers and suppliers can also be revoked from Medicare based on a federal exclusion or debarment, license suspension or revocation, or determination that the provider or supplier is no longer operational.⁶

Before CMS implemented new procedures for reviewing the criminal backgrounds of existing and prospective Medicare providers and suppliers in April 2014, the agency relied on verifying applicants' self-reported adverse legal actions by checking whether providers and suppliers had previously lost their licenses because of a conviction such as a crime against a person. It did so by checking state medical-licensing boards in the state where the provider was enrolling and any other state where the provider self-reported an adverse legal action. CMS also checked whether the Department of Health and Human Services (HHS) Office of Inspector General (OIG) had excluded providers and suppliers from participating in federal health-care programs. According to CMS, it also relied on Zone Program Integrity Contractors (ZPIC) to identify providers and suppliers with a conviction history. ZPICs are required to investigate allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources; proactively identify incidents of potential fraud that exist within its service area; and explore available sources of fraud leads. Through their investigations, the ZPICs may determine that a particular provider's

⁴In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which provided CMS with increased authority to combat potential fraud, waste, and abuse in Medicare. PPACA requires all existing provider and supplier information to be revalidated by 2015. PPACA, § 6401, 124 Stat. 119, 749, amended by § 10603, 124 Stat. 119, 1006 (codified at 42 U.S.C. § 1395cc(j)). CMS retains the authority to require a provider or supplier to revalidate off-cycle when certain compliance-related concerns arise.

⁵42 C.F.R. § 424.535 and 42 C.F.R. § 424.530.

⁶42 C.F.R. § 424.535.

or supplier's Medicare billing privileges should be revoked, such as when a provider has a felony conviction, and would refer the case to CMS for further review and action. Using these methods, CMS identified providers it deemed ineligible for the program and could remove. However, CMS did not always have access to federal or state offense information that identified the cause of a provider's or supplier's license suspension or exclusion from participating in federal health-care programs, which could have led to an earlier ineligibility date.

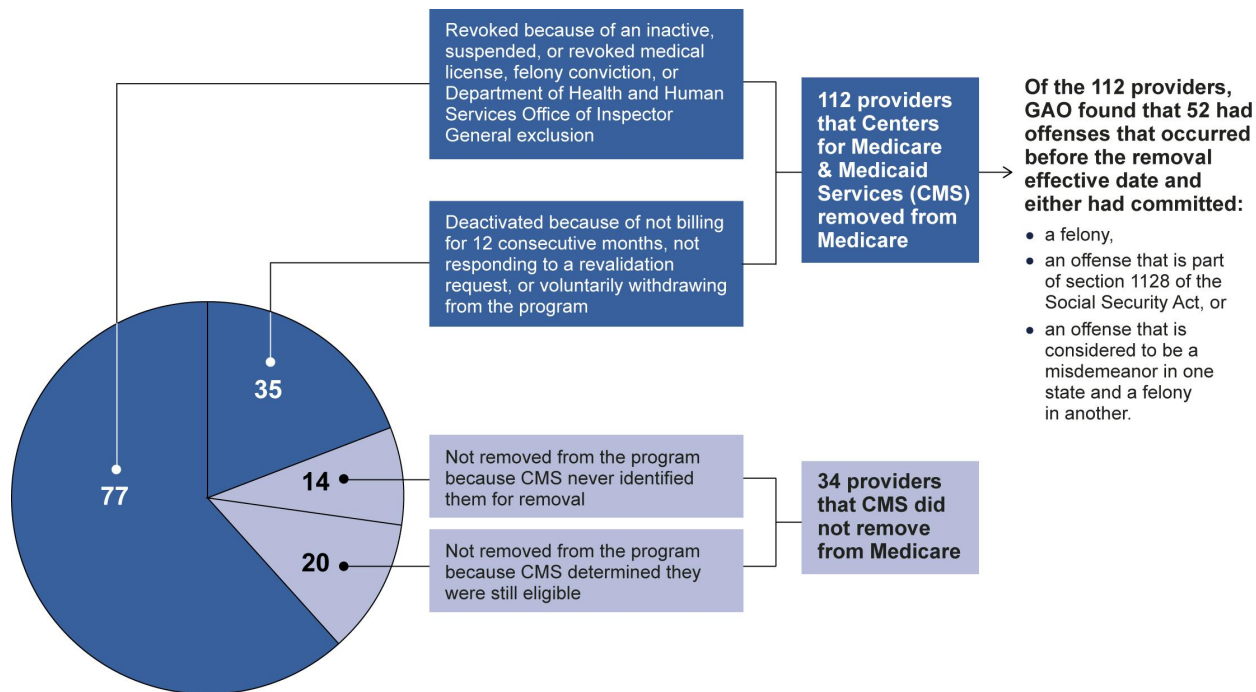
We found instances of providers who were enrolled in PECOS as of March 2013—that is, providers who enrolled before CMS implemented new controls in April 2014—who had billed Medicare for services that took place after the effective date of conviction that ultimately made them ineligible for the program. Not all of the providers listed in the Federal Bureau of Prisons or National Sex Offender Registry data are automatically revoked by CMS. Depending on the severity of the offense and whether the applicant self-reported the offense, a provider may still be allowed to enroll into the Medicare program. To review the criminal backgrounds of providers in PECOS, we compared a list of approximately 1.2 million unique providers in PECOS as of March 2013 to Federal Bureau of Prisons and National Sex Offender Registry data as of February 2014.⁷ We found that 146 providers either were incarcerated for a federal offense, such as embezzlement and income-tax evasion, or were convicted of a crime that required them to register as a sex offender, such as sexual battery or sexual assault.⁸ Of these providers, we determined that CMS had removed 112 providers from the Medicare program as a result of procedures in place prior April 2014. Of these 112, CMS revoked 77 providers for felony conviction, licensure, or exclusion issues and deactivated 35 for not billing the program consecutively within a year, not responding to revalidation requests, or requesting to voluntarily withdraw from the program.⁹ See figure 1 for a summary of actions taken by CMS.

⁷Our review focused on unique physicians and nonphysicians, such as physician assistants, clinical social workers, and nurse practitioners. As previously mentioned, we did not review suppliers such as DMEPOS suppliers, HHA, or providers that did not have an individual Social Security number, name, and date of birth associated with their PECOS profiles.

⁸Federal offenses, resulting in an incarceration in the Federal Bureau of Prisons system, included filing false corporate tax returns, distributing controlled substances, conspiring to commit health-care fraud, and committing wire and mail fraud, among others. Felonies that required an individual to register as a sex offender included illegal use of a minor in nudity-oriented material, gross sexual imposition, and sexual exploitation of a minor, among others. Because CMS is only required to revoke providers with specifically enumerated health-care related offenses, not all providers listed in the Federal Bureau of Prisons or the National Sex Offender Registry data would be automatically revoked by CMS. Depending on the severity of the offense and whether the applicant self-reported the offense, a provider may be allowed to still enroll into the Medicare program.

⁹Deactivation is another tool that CMS has in place outside of the criminal verification process that can assist in removing the billing privileges of potentially ineligible providers not identified through criminal background controls. When providers or suppliers are in deactivation status, their billing privileges are stopped; however, they can be restored upon submission of updated information to PECOS.

Figure 1: CMS Actions for the 146 Providers Included in Our Review with Criminal Backgrounds between January 1997 and September 2015



Source: GAO analysis of CMS data. | GAO-16-365R

Data Table for Figure 1: CMS Actions for the 146 Providers Included in Our Review with Criminal Backgrounds between January 1997 and September 2015

Revoked because of an inactive, suspended, or revoked medical license, felony conviction, or Department of Human Services Office of Inspector General exclusion	Deactivated because of not billing for 12 consecutive months, not responding to a revalidation request, or voluntarily withdrawing from the program	Not removed from the program because CMS never identified them for removal	Not removed from the program because CMS determined they were still eligible
77	35	14	20

Of the 112 providers that CMS removed from the Medicare program, we found that 52 either had committed: (1) a felony, (2) an offense that is part of section 1128 of the Social Security Act,¹⁰ or (3) an offense that is considered to be a misdemeanor in one state and a felony in another.¹¹ All of these offenses occurred before the removal effective date that was provided to us by the MACs. Because CMS did not initially have, and therefore did not use, the original felony conviction date that

¹⁰Under section 1128 of the Social Security Act, exclusions from federal health programs are permissive under certain circumstances and mandatory in others. 42 U.S.C. § 1320a-7. Mandatory exclusions are required for felony convictions relating to health-care fraud or controlled substances, and any convictions relating to patient abuse/neglect or to the delivery of Medicare or state health-care programs.

¹¹As mentioned above, CMS may deny or revoke a providers' or supplier's enrollment in the Medicare program if, within the 10 years before enrollment or revalidation of enrollment, the provider, supplier, or any owner or managing employee of the provider or supplier was convicted of a federal or state felony offense, including certain felony crimes against persons, that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.

ultimately made the provider ineligible to participate in Medicare, it missed an opportunity to revoke these providers at an earlier date. Instead, CMS officials used other information that CMS identified, such as reported dates of medical-license suspensions, HHS OIG exclusion dates, and deactivation dates to calculate effective dates to remove providers from Medicare. Although CMS is not required to revisit these revocations or deactivations after removing the providers, doing so would assist the agency in determining whether earlier felony convictions, identified through automated screening, provide additional information on whether an earlier effective date for revocation from the program is applicable, and whether a potential overpayment occurred.¹²

Of these 52 potentially ineligible providers, we identified 10 providers that were paid about \$1.1 million by Medicare through the fee-for-service program between the time they were initially convicted of a crime and the time that they were officially removed from the program. We will refer all 52 providers to CMS for further review and action, as appropriate. Current CMS policies allow the agency to revisit removal actions to assess whether there are additional opportunities to recoup potentially overpayments.

For the remaining 34 providers that matched our federal criminal databases, but that CMS did not remove, we examined whether the providers engaged in actions that would potentially disqualify them from the Medicare program. In September 2015, we followed up with the MACs to determine the status of these 34 providers still active in PECOS. On the basis of the MACs' responses, 20 out of the 34 providers remained active in PECOS because the provider self-reported their adverse legal action; CMS did not deem the adverse legal action to be detrimental to the Medicare program; or, the action occurred more than 10 years prior to the date the provider was enrolled or revalidated. CMS did not remove the remaining 14 providers because the providers did not self-report their adverse legal actions and CMS was not aware of the provider's adverse legal actions. We found that the 14 providers were convicted and incarcerated for a federal offense or were convicted of a crime that required them to register as a sex offender, potentially falling under CMS's authority to revoke them from the Medicare program. Six out of these 14 providers were paid by Medicare about \$195,000 during the year after their conviction, while the other 8 were not paid anything by Medicare.¹³ As previously stated, CMS has discretionary authority to revoke providers from the Medicare program if, in the preceding 10 years, the provider, supplier, or any owner, or managing employee of the provider or supplier was convicted of a federal or state felony offense that CMS has determined to be detrimental to the best interest of the Medicare program and its beneficiaries.¹⁴ While some of the 14 providers we identified had similar categories of offenses as those that were removed—such as sex-related offenses as shown in table 1—without additional details on these cases, we cannot determine whether the offenses of the 14 providers warranted that these providers be revoked from the Medicare program. We will refer all 14 cases to CMS for further review.

As previously mentioned, we plan to refer 66 potentially ineligible providers to CMS. This group is made up of 52 providers whose offenses occurred before the removal effective date that was

¹² In providing technical comments to a copy of the draft correspondence, CMS noted that it is able to backdate the revocation to the date of the offense regardless of when it is found.

¹³ For the 14 providers that were not revoked, we calculated the Medicare claims paid from the conviction date to a year after their conviction date. We used 1 year to calculate the Medicare claims paid because CMS regulations allow for the revocation of a provider from the Medicare program under a reenrollment bar that lasts a minimum of 1 year. The Medicare claims information includes the fee-for-service program only.

¹⁴ 42 C.F.R. § 424.535.

provided to us by the MACs and 14 providers that CMS did not remove. Out of the 66 providers that we plan to refer, 16 were paid about \$1.3 million by Medicare through the fee-for-service program. Specifically, 10 providers were paid about \$1.1 million between the time they were initially convicted of a crime and the time that they were officially removed from the program, and six other providers that were not removed were paid about \$195,000 during the year after their conviction.

Table 1: Types of Offenses Committed by All 146 Providers That We Either Referred or Did Not Refer for Further Review

Offense description ^a	Referred		Not referred
	Later effective date	Centers for Medicare & Medicaid Services (CMS) never identified for removal	CMS determined was eligible, used an earlier effective date, or out of scope
Sex-related offenses ^b	20	7	41
Drug and controlled substance-related offenses ^c	11	2	6
Health-care related offenses ^d	11	1	18
Mail and wire fraud	No data	1	3
Theft/embezzlement-related offenses ^e	1	No data	1
Possession of firearm	No data	1	2
Assault	1	No data	No data
Conspiracy to commit bribery	No data	No data	1
Conspiracy	1	No data	No data
Conspiracy to pay and receive health-care kickbacks	1	No data	2
Anti-kickback violation	No data	No data	1
Obscene communication/material	1	No data	2
Crimes against person	No data	No data	1
Income-tax evasion	4	2	2
Illegal remunerations	1	No data	No data
Subtotal	52	14	80
Total referred / not referred	66		80

Source: GAO. | GAO-16-365R

^aThe determination of whether to revoke the billing privileges of an individual provider or supplier varies depending on the facts and circumstances of each application. CMS may revoke the billing privileges of a provider or supplier from the Medicare program under the specific authorities listed in 42 C.F.R. § 424.535.

^bSex-related offenses include rape, statutory rape, sex assault, sex offense against child, indecent exposure to adult, sex distribution of visual depiction of minor engaging in sexually explicit conduct, distribution of child pornography, possession of child pornography, lewd or lascivious acts with minor, sex offense, commercial sex, exploitation, and enticement.

^cDrug and controlled substance–related offenses include distribution of controlled substances, conspiracy to distribute controlled substance, conspiracy to distribute drugs, conspiracy to manufacture a controlled substance, conspiracy to import and distribute human growth hormone, and receiving in interstate commerce a misbranded drug.

^dHealth care–related offenses include health-care fraud, conspiracy to commit health-care fraud, and false statement related to health-care matters.

^eTheft- and embezzlement-related offenses include theft of government property and theft and embezzlement of employee benefits.

CMS Has Implemented Additional Steps to Facilitate Criminal-Background Checks on Medicare Providers

In April 2014, CMS implemented steps that provide more information on the criminal backgrounds of existing and prospective Medicare providers and suppliers than it obtained previously. Specifically, in order to improve its verification process, CMS supplemented its criminal-background controls by screening provider and supplier criminal backgrounds through an automated screening process.¹⁵ Enclosure I outlines CMS's current criminal verification process for Medicare providers and suppliers.

Under this process, MACs are to review an applicant's self-reported license information and whether the applicant has been excluded from participating in federal health-care programs. In addition, CMS receives information from ZPICs, discussed earlier in this correspondence, which provide a conviction history on providers and suppliers they investigate. The automated-screening contractor is to supplement these controls by conducting criminal-background checks on providers, suppliers, and organization principals (i.e., individuals with 5 percent or more ownership in the business). The contractor uses third-party vendor applications available to the public to conduct the criminal-background checks.¹⁶ As a result, CMS and its contractors obtain greater access to data about federal and state offenses and the ability to conduct a more comprehensive review of provider and supplier criminal backgrounds than in the past.

According to CMS, the automated-screening contractor began with an initial screening of about 1.6 million active providers and suppliers in PECOS. The initial screening included checking for federal and state offenses, among other checks. According to CMS, the contractor also continually monitors all providers and suppliers by conducting weekly screenings of about 12,000 providers and suppliers per week. This continual monitoring consists of verifying that licenses remain current and whether any new offenses exist. The 12,000 providers and suppliers include a combination of new Medicare enrollments, revalidations, and changes of providers' or suppliers' PECOS enrollment information. The weekly screenings are prioritized by initial enrollments over updates and individuals over organizations.¹⁷ In addition, the contractor applies criteria provided by CMS, such as selecting felony convictions that occurred within the past 10 years, to narrow search results and focus on the offenses that CMS would more likely deem as grounds for making a provider or supplier ineligible to participate in Medicare. The contractor then flags providers or suppliers with new offenses and reviews their information to determine whether to recommend that CMS take action. Finally, the contractor compiles the information into a weekly criminal-background report and provides it to CMS.

According to CMS officials, they review the weekly criminal-background report and make a final determination on whether the provider or supplier should be revoked from the Medicare

¹⁵CMS awarded a contract in 2011 to an automated-screening contractor with the intent to automate functions that the MACs previously performed manually, which included criminal-background verifications. The automated-screening contractor was tasked with developing and applying methods to automate the verification of all existing and newly enrolling providers and suppliers. These verifications included checking whether providers and suppliers have valid licenses and accreditations, whether they are on the HHS OIG list of providers and suppliers excluded from participating in federal health-care programs, and whether they have criminal-background histories that would prevent them from participating in the Medicare program.

¹⁶A third-party vendor application is a service that collects data on federal and state criminal offenses.

¹⁷The MACs also have the ability within PECOS to override the automated selection process and force a specific enrollment to the front of the screening priority queue.

program based on the type of felony conviction and other supporting information. As mentioned previously, an evaluation of the effectiveness of the new automated-screening procedure was beyond the scope of this audit. However, on the basis of information provided by CMS, the agency's new procedures provide more information regarding the provider's or the supplier's offenses, which could lead to a licensure revocation or other disqualifier from Medicare. Further, CMS officials report that the agency uses this information to determine whether the earliest date is applicable as the effective date of the provider's or supplier's revocation. If CMS implements this process as designed, the new procedures should help to address the limitation that we identified in this correspondence, where in some cases CMS revoked providers and suppliers using effective dates that occurred months or years after the provider or supplier committed the potentially disqualifying offense.

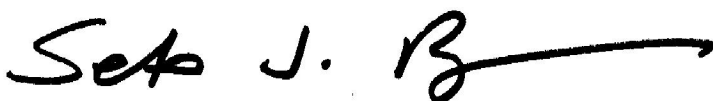
Agency Comments and Our Evaluation

We provided a draft of this correspondence to HHS for comment. In its written comments, reproduced in enclosure II, the agency stated that it is strongly committed to program integrity efforts in Medicare and described its efforts to strengthen provider enrollment and screening. HHS stated that it will review the list of potentially ineligible providers we referred to CMS and take any appropriate actions. However, in its comments, HHS only made reference to the 14 providers we identified as potentially requiring revocation from the Medicare program. These 14 providers, who CMS did not yet remove, received about \$195,000 in Medicare funds during the year after their convictions—while they were potentially ineligible because of convictions that were either not identified or not reported to CMS. In line with HHS's commitment to strengthen Medicare program integrity, we also encourage the agency to review the 52 other providers that we reported in our correspondence that we will refer to the agency. These providers were already removed from the Medicare program by CMS, but had offenses that occurred before the effective date CMS used to remove them from the program. Some of these providers were paid a total of \$1.1 million by CMS for providing services during that potentially ineligible time. Along with its letter, HHS also provided technical comments that were incorporated into this correspondence, as appropriate.

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We are sending copies of this correspondence to appropriate congressional committees, the Acting Administrator of CMS, and other interested parties.

If you or your staff have any questions about this correspondence, please contact me at (202) 512-6722 or badgdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this correspondence. GAO staff who made key contributions to this correspondence include Latesha Love (Assistant Director), Ariel Vega (Analyst-in-Charge), and Gloria Proa.

A handwritten signature in black ink, reading "Seto J. Bagdoyan" with a long horizontal stroke extending to the right.

Seto J. Bagdoyan
Director, Forensic Audits and Investigative Service

List of Requesters

The Honorable Ron Johnson
Chairman
The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Susan M. Collins
Chairman
The Honorable Claire McCaskill
Ranking Member
Special Committee on Aging
United States Senate

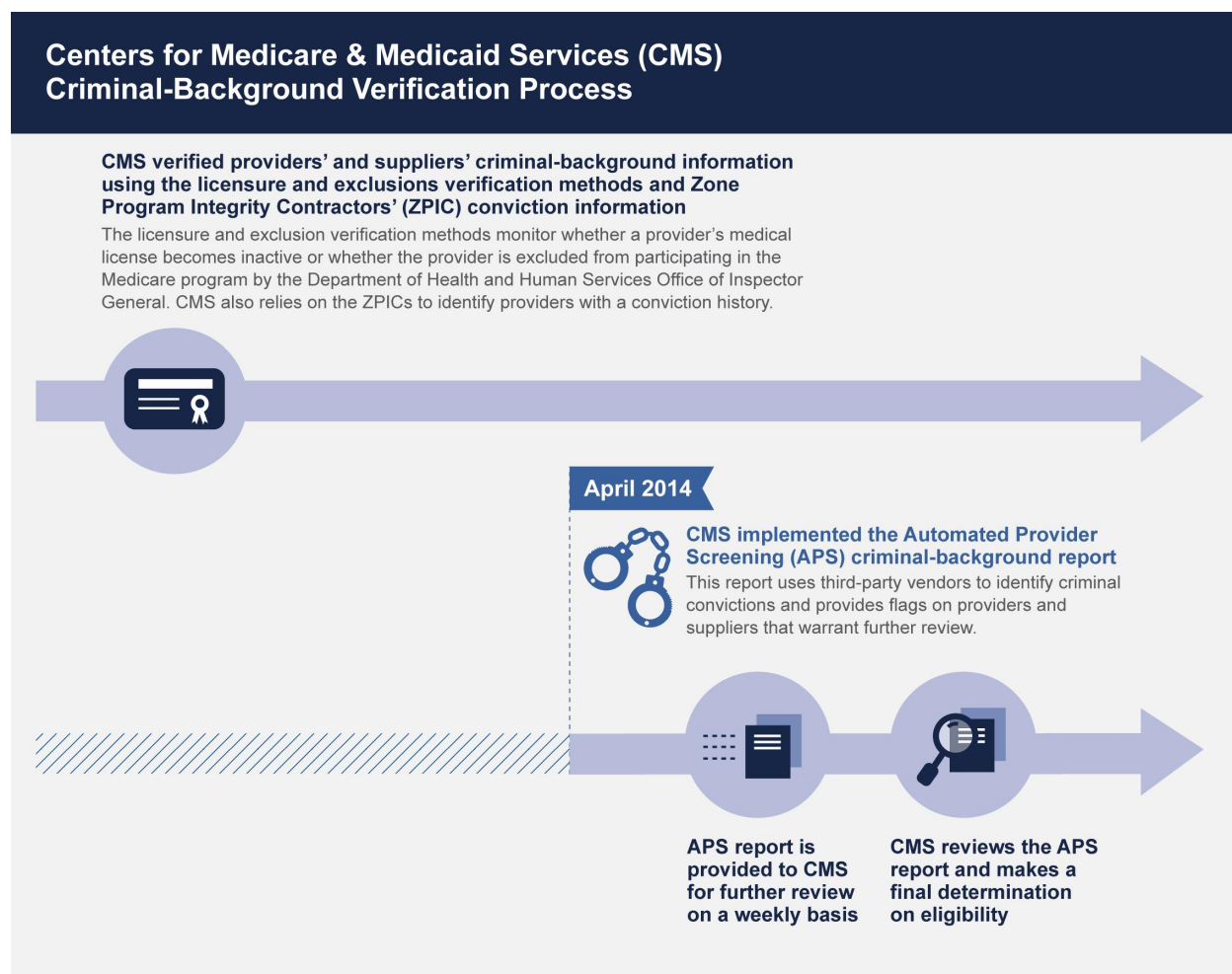
The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Sheldon Whitehouse
United States Senate

Enclosure I: CMS's Criminal-Background Verification Process

In order to improve its verification process, in April 2014 the Centers for Medicare & Medicaid Services (CMS) supplemented its criminal-background controls by screening provider and supplier criminal backgrounds through an automated screening process. Figure 2 outlines CMS's current criminal-verification process for Medicare providers and suppliers.

Figure 2: CMS's Current Criminal-Background Verification Process



Source: GAO. | GAO-16-365R

Enclosure II: Agency Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 11 2016

Seto Bagdoyan
Director, Forensic Audits and Investigative Service
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare: Opportunities Exist to Recover Potential Improper Payments to Providers with Criminal Backgrounds*" (GAO-16-365R).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in dark ink, reading "Jim R. Esquea", is positioned above the printed name and title.

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE: OPPORTUNITIES EXIST TO RECOVER POTENTIAL IMPROPER PAYMENTS TO PROVIDERS WITH CRIMINAL BACKGROUNDS (GAO-16-365R)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity efforts in Medicare. In addition to the improvements that have been implemented as a result of our increased authority provided by the Affordable Care Act to strengthen provider enrollment and screening, HHS works to continuously enhance the provider enrollment and revalidation process.

In February 2011, HHS finalized regulations to implement categorical risk-based screening of newly enrolling Medicare providers and suppliers and revalidate all current Medicare providers and suppliers under new requirements established by the Affordable Care Act. Limited risk providers and suppliers undergo verification of licensure, verification of compliance with federal regulations and state requirements, and perform various database checks. Moderate and high risk providers and suppliers undergo additional screening, including unannounced site visits. Additionally, high risk individuals with a five percent or greater direct or indirect ownership interest in a high risk provider or supplier must consent to criminal background checks including fingerprinting.

Since these regulations were issued, more than one million providers and suppliers have been subject to the new screening requirements. Over 500,000 provider and supplier practice locations had their billing privileges deactivated as a result of revalidation and other screening efforts, and more than 34,000 provider and supplier enrollments were revoked. In addition, HHS has performed nearly 250,000 site visits on Medicare providers and suppliers. HHS uses site visits to verify that a provider's or supplier's practice location meets requirements and helps prevent questionable providers and suppliers from enrolling in the Medicare program.

In April 2014, HHS partnered with an automated screening contractor to screen providers and suppliers with criminal background histories that would prevent them from enrolling in Medicare. HHS has since screened more than 1.6 million active providers and suppliers through this process and regularly screens newly enrolled providers and suppliers as well as re-screening currently enrolled providers and suppliers. The automatic screening process flags necessary application information for contractor review and verification.

In February 2016, HHS proposed new provider enrollment regulations to help make certain that entities and individuals who pose risks to the Medicare program and beneficiaries are kept out of or removed from Medicare for extended periods. These enhancements, if finalized, would allow CMS to take action to remove or prevent the enrollment of health care providers and suppliers that attempt to circumvent Medicare's enrollment requirements through name and identity changes as well as through elaborate, inter-provider relationships.

HHS has made significant progress in reducing the number of questionable providers and suppliers enrolling in Medicare. As GAO noted in this report, of the 1.2 million providers and suppliers reviewed, GAO only identified 14 of them as potentially requiring revocation from the Medicare program. HHS will review the list of potentially ineligible providers GAO refers to CMS and take any appropriate actions.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE: OPPORTUNITIES EXIST TO RECOVER POTENTIAL IMPROPER PAYMENTS TO PROVIDERS WITH CRIMINAL BACKGROUNDS (GAO-16-365R)

HHS thanks GAO for their efforts on this report and looks forward to working with GAO on this and other reports in the future.

Accessible Text for Enclosure II: Agency Comments from the Department of Health and Human Services

Page 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington, DC 20201

MAR 11 2016

Seto Bagdoyan

Director, Forensic Audits and Investigative Service

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicare: Opportunities Exist to Recover Potential Improper Payments to Providers with Criminal Backgrounds " (GAO-16-365R).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea

Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE: OPPORTUNITIES EXIST TO RECOVER POTENTIAL IMPROPER PAYMENTS TO PROVIDERS WITH CRIMINAL BACKGROUNDS (GAO-16-365R)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity efforts in Medicare. In addition to the improvements that have been implemented as a result of our increased authority provided by the Affordable Care Act to strengthen provider enrollment and

screening, HHS works to continuously enhance the provider enrollment and revalidation process.

In February 2011, HHS finalized regulations to implement categorical risk-based screening of newly enrolling Medicare providers and suppliers and revalidate all current Medicare providers and suppliers under new requirements established by the Affordable Care Act. Limited risk providers and suppliers undergo verification of licensure, verification of compliance with federal regulations and state requirements, and perform various database checks. Moderate and high risk providers and suppliers undergo additional screening, including unannounced site visits. Additionally, high risk individuals with a five percent or greater direct or indirect ownership interest in a high risk provider or supplier must consent to criminal background checks including fingerprinting.

Since these regulations were issued, more than one million providers and suppliers have been subject to the new screening requirements. Over 500,000 provider and supplier practice locations had their billing privileges deactivated as a result of revalidation and other screening efforts, and more than 34,000 provider and supplier enrollments were revoked. In addition, HHS has performed nearly 250,000 site visits on Medicare providers and suppliers. HHS uses site visits to verify that a provider's or supplier's practice location meets requirements and helps prevent questionable providers and suppliers from enrolling in the Medicare program.

In April 2014, HHS partnered with an automated screening contractor to screen providers and suppliers with criminal background histories that would prevent them from enrolling in Medicare. HHS has since screened more than 1.6 million active providers and suppliers through this process and regularly screens newly enrolled providers and suppliers as well as re-screening currently enrolled providers and suppliers. The automatic screening process flags necessary application information for contractor review and verification.

In February 2016, HHS proposed new provider enrollment regulations to help make certain that entities and individuals who pose risks to the Medicare program and beneficiaries are kept out of or removed from Medicare for extended periods. These enhancements, if finalized, would allow CMS to take action to remove or prevent the enrollment of health care providers and suppliers that attempt to circumvent Medicare's enrollment requirements through name and identity changes as well as through elaborate, inter-provider relationships.

HHS has made significant progress in reducing the number of questionable providers and suppliers enrolling in Medicare. As GAO noted in this report, of the 1.2 million providers and suppliers reviewed, GAO only identified 14 of them as potentially requiring revocation from the Medicare program. HHS will review the list of potentially ineligible providers GAO refers to CMS and take any appropriate actions.

Page 3

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE: OPPORTUNITIES EXIST TO RECOVER POTENTIAL IMPROPER PAYMENTS TO PROVIDERS WITH CRIMINAL BACKGROUNDS (GAO-16-365R)

HHS thanks GAO for their efforts on this report and looks forward to working with GAO on this and other reports in the future.

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